SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Filing at a Glance

Company: Guarantee Trust Life Insurance Company

Product Name: Amendment Rider	SERFF Tr Num: GRTT-128294074	State: Arkansas
TOI: H07I Individual Health - Specified Disease - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H07I.001 Critical Illness	Co Tr Num: RA12-5	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Joan Jannotta, Ann Ryan	Disposition Date: 06/12/2012
	Date Submitted: 06/06/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number: RA12-5	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filing concurrently
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 06/12/2012
	State Status Changed: 06/12/2012
Deemer Date:	Created By: Joan Jannotta
Submitted By: Joan Jannotta	Corresponding Filing Tracking Number:

Filing Description:

Individual Accident and Health Insurance
Amendment Rider RA12-5
Outline of Coverage OCG1132-AR (5/12)
Application APPH3A-11 (5/12)

We are submitting the above referenced forms for the Department’s review and approval.

Amendment Rider RA12-5 is new and not intended to replace any forms currently on file at the Department. The purpose of the rider is to revise the “Restoration of Policy Benefits” provision in previously approved policy form G1132-

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

AR. Policy form G1132-AR was approved by your Department on December 20, 2011 under serff filing number GRTT-127906558 .

As previously written, the “Restoration of Benefits” provision was not clear. To avoid any misunderstanding we have revised the provision language. There is no change in rates as this was the intent of the policy language when it was originally drafted.

To date, we have issued very few of these policies. We will not add the rider to inforce business. We will accept the additional risk for these policyholders at no extra charge.

We are also submitting a revised copy of the outline of coverage and application. They replace the outline and application that was approved with the above referenced serff filing.

The outline has been revised to include the clarified Restoration of Policy Benefits language.

The following sentence has been added to the authorization section of the application as required by the MIB: “I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to the MIB. This is the only change to the application.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the application may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

Thank you for your time and attention to this filing. We are most anxious to receive approval of this rider to so that our contract language will read as intended. If you have any questions, please contact me toll free at 800-338-7452, ext. 5730 or e-mail me at jjannotta@gtlic.com.
State Narrative:

Company and Contact

Filing Contact Information

Joan Jannotta,	jjannotta@gtlic.com
1275 Milwaukee Ave.	847-904-5730 [Phone]
Glenview, IL 60025	847-699-0093 [FAX]

Filing Company Information

Guarantee Trust Life Insurance Company	CoCode: 64211	State of Domicile: Illinois

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

1275 Milwaukee Avenue
1275 Milwaukee Avenue
Glenview, IL 60025
(847) 460-4772 ext. [Phone]

Group Code: 687
Group Name:
FEIN Number: 36-1174500

Company Type: Mutual
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	IL, our state of domicile, charges $50 per form but no fee for outlines, Arkansas filing fee is $50 per form, $50 X 3 = $150.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance Company	$150.00	06/06/2012	59802358

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/12/2012	06/12/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Application	Joan Jannotta	06/08/2012	06/08/2012
Supporting Document	Statement of Variability	Joan Jannotta	06/08/2012	06/08/2012

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
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Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Disposition

Disposition Date: 06/12/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
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Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document *(revised)*	Application	Approved-Closed	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Amendment Rider	Approved-Closed	Yes

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Amendment Letter

Submitted Date: 06/08/2012

Comments:

I've added a Statement of Variability

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Application

Comment: APPH3A-11 (5/12)

APPH3A-11 (5 12).pdf

User Added -Name: Statement of Variability

Comment:

Statement of Variability.pdf

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Form Schedule

Lead Form Number: RA12-5

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/12/2012	RA12-5	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment Rider	Initial		44.000	RA12-5.pdf

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

AMENDMENT RIDER

EFFECTIVE DATE: _____

This Rider is made a part of Your Policy as of the Effective Date shown above. If no date is shown, it is effective as of the Effective Date of the Policy to which this Rider is attached.

The Policy is hereby amended as follows:

The "**RESTORATION OF POLICY BENEFITS"** provision is deleted and replaced with the following:

"RESTORATION OF POLICY BENEFITS
This Policy's Maximum Benefit Period or Limited Benefit Period for any One Benefit Period will be fully restored when there has been no payment of benefits of a Covered Condition for twelve (12) consecutive months. The Restoration of Policy Benefits does not apply to Alzheimer's disease or Paralysis.

If the Policy includes coverage for Cancer, as shown on the Policy Schedule Page, benefits for the reoccurrence of a previously diagnosed Cancer are subject to Documented Medical Evidence that supports a Cancer's Period of Remission. We retain the right to have such Documented Medical Evidence reviewed by an Oncologist of Our choice.

The Restoration of Policy Benefits is subject to the Lifetime Maximum Benefit shown in the Schedule."

The following definitions are added:

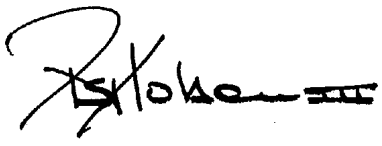
Documented Medical Evidence includes but is not limited to appropriate radiology, diagnostic testing, laboratory testing, and physical examination by an Oncologist.

Oncologist means a medical Doctor, other than You or a member of Your Immediate Family, specializing in the diagnosis and treatment of Cancer.

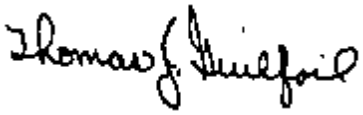
Period of Remission means for at least one (1) full year during which a Covered Person has been free of Cancer treatment(s) (including preventive and maintenance drugs), as supported by Documented Medical Evidence. Cancer treatment does not include follow-up visits or testing that is performed for purposes that confirm Cancer is in remission.

This Rider is subject to all terms, definitions, provisions, limitations and exclusions of the Policy except when specifically changed by this rider."

Signed at Guarantee Trust Life Insurance Company in Glenview, Illinois by



President



Secretary

Licensed Resident Agent (If Required): _____

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
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Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/12/2012

Comments:
Readability Certification
Attachment:
Readability Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/12/2012

Comments:
APPH3A-11 (5/12)
Attachment:
APPH3A-11 (5 12).pdf

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	06/12/2012
Bypass Reason:	Not applicable		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	06/12/2012

Comments:
Outline of Coverage
Attachment:
OCG1132-AR (5 12).pdf

	Item Status:	Status

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Satisfied - Item: Statement of Variability — Approved-Closed — **Date:** 06/12/2012

Comments:

Attachment:

Statement of Variability.pdf

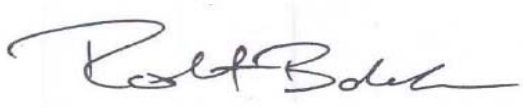
CERTIFICATE OF READABILITY

Form Number(s): RA12-5, OCG1132-AR (5/12), APPH3A-11 (5/12)

Flesch Test Score(s): 44, 45, 45 respectively

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

GUARANTEE TRUST LIFE INSURANCE COMPANY



Robert Baluk, General Counsel

Date: June 4, 2012

Application for Critical Care Insurance to: Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue, Glenview, IL 60025 (800) 338-7452

AGENT NOTE: Please pre-qualify the Applicant(s) with Section C prior to completing the application

Application for: ☐ New Coverage ☐ Reinstatement ☐ Increase of Benefits

If Reinstatement or Increase requested, please list GTL policy/certificate number(s) affected:_____

A. APPLICANT(S) INFORMATION

MAIL POLICY TO: ☐ AGENT ☐ INSURED

APPLICANT

1. Last Name _____ 2. First _____ 3. M.I _____

4. Social Security #_____ 5. ☐ Male ☐ Female 6. Age _____ 7. Date of birth_____

8. Have you used any tobacco products in the past 12 months? ☐ Yes ☐ No

SPOUSE:

9. Last Name _____ 10. First _____ 11. M.I _____

12. Social Security #_____ 13. ☐ Male ☐ Female 14. Age _____ 15. Date of Birth_____

16. Have you used any tobacco products in the past 12 months? ☐ Yes ☐ No

DEPENDENTS:

D1. Last Name _____ First _____ M.I _____
☐ Male ☐ Female Age _____ Date of Birth_____ Social Security #_____

D2. Last Name _____ First _____ M.I _____
☐ Male ☐ Female Age _____ Date of Birth_____ Social Security #_____

For additional dependents, please attach a separate piece of paper, signed and dated by the applicant, including the above information for each dependent.

CONTACT:

17. Street Address_____

18. City_____ 19. State_____ 20. Zip Code_____

21. Telephone_____ 22. Email Address _____

BENEFICIARY (Required Information):

Primary Beneficiary_____ Relationship_____

Contingent Beneficiary_____ Relationship_____

[B. COVERAGE SELECTION & PREMIUMS

1. Choose a Plan:	2. Choose Benefit Amount	3. Choose Benefit Period
Plan Type (Select 1): A B C	*Monthly Base Benefit Amount: *Minimum $500, maximum $3,000 in $250 increments	**Maximum Benefit Period for covered conditions: 6 Months | 12 Months | 18 Months | 24 Months
Applicant: ☐ ☐ ☐	$_____	☐ ☐ ☐ ☐
Spouse: ☐ ☐ ☐	$_____	☐ ☐ ☐ ☐
Depndt(s): ☐ ☐ ☐	$500 (for all dependents)	☐ ☐ ☐ ☐
Plan A = Critical Care *Plan B = Cancer Care+* *Plan C = Cardiac Care+*	*Assisted Living Facility and Nursing Home Benefits are paid in addition to the base. The ALF benefit is 50% of the base, NH benefit is 100% of the base.*	***Limited Benefit Period applies to specific covered conditions. See Outline of Coverage.]*

4. Choose Premium Payment Mode:

☐ Monthly Bank Draft ☐ Annual
☐ Semi-Annual ☐ Quarterly
Effective Date: _____
Draft Date (other than the 29th, 30th and 31st):_____

5. Return of Premium Rider: ☐ Yes ☐ No

6. Premiums:

Premiums include an annual $25 Policy Fee.
TOTAL: $ _____

C. PRE QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

1. In the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:

AIDS or ARC	Kidney Dialysis
ALS (Lou Gehrig's Disease)	Kidney Disease, Chronic
Alzheimer's Disease	Liver Disease, Chronic
Central Nervous System Disease	Mental Retardation
Cerebral Palsy	Motor Neuron Disease
Cirrhosis	Multiple Sclerosis
Crohn's Disease	Muscular Dystrophy
Cystic Fibrosis	Paralysis
Dementia	Parkinson's Disease
Hepatitis B, or C. Chronic	Respiratory or Lung Disease, Chronic
HIV positive	(other than controlled asthma)
Huntington's Disease	Ulcerative Colitis

2. In the past 5 years has anyone proposed for insurance been treated for drug or alcohol abuse or abused alcohol or drugs or had abnormal test results relating to alcohol or drug use or are currently confined to an assisted living facility or a nursing home?

3 For any of the conditions listed in 1 and 4 A-B for which benefits are being applied for, within the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a practitioner but has not yet done so or experienced any symptoms that would have caused an ordinarily prudent person to seek advice from a medical practitioner?

4. In the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:
   A. Leukemia, malignant melanoma, lymphoma, sarcoma, or any other type of cancer (excluding skin cancer) or any tumor of the brain?
   B. Disease of the heart or heart valves, heart attack, chest pain, coronary bypass, angioplasty, stent placement, angina, heart arrhythmia requiring treatment, cardiomyopathy, congenital heart defect, abnormal heart test, stroke, Transient Ischemic Attack (TIA), peripheral vascular disease, unoperated aneurysm, brain hemorrhage or diabetes treated with insulin?

5. For anyone proposed for insurance under the age of 60, did 2 or more of your natural parent(s), sister(s), brother(s), either living or dead suffer from:
   A. Cancer before the age of 60?
   B. Stroke or heart disease or diabetes before the age of 60?

6. Is any person proposed for insurance taking any prescription medication? If yes please list below.

Name of Person	Name of Medication	Reason for Medication(s)	Dosage

APPLICANT'S ANSWERS

Question	YES	NO	Action
1, or 2, or 3	☐	☐	If "YES," do not submit the application
4A, or 5A	☐	☐	If "YES," Cancer Care coverage not available } If both "YES", do not submit application
4B, or 5B	☐	☐	If "YES," Cardiac Care coverage not available

SPOUSE'S ANSWERS

Question	YES	NO	Action
1, or 2, or 3	☐	☐	If "YES," Spouse does not qualify for benefits
4A, or 5A	☐	☐	If "YES," Cancer Care coverage not available } If both "YES", does not qualify for benefits
4B, or 5B	☐	☐	If "YES," Cardiac Care coverage not available

DEPENDENT'S ANSWERS

Question	YES	NO	Action
1, or 2, or 3	☐	☐	If "YES," Dependent(s)_____ does/do not qualify for benefits
4A, or 5A	☐	☐	If "YES," Cancer Care coverage not available } If both "YES", does/do not qualify for benefits
4B, or 5B	☐	☐	If "YES," Cardiac Care coverage not available

D. COVERAGE INFORMATION

APPLICANT

1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued? ☐ No ☐ Yes (If "YES," please complete the Replacement Form.)
   If "YES," with which company? _____

AGENT'S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by Guarantee Trust Life Insurance Company. To the best of my knowledge and belief, the insurance applied for:

☐ Is, or

☐ Is not likely to replace or change existing insurance or annuities.

_____

Agent's Name (Printed) Agent Code

_____

Agent's Signature Agent's Email Address Date

AUTHORIZATION/AGREEMENT

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that insurance applied for will not become effective until: a) approved and issued by GTL; b) I (We) have been furnished written notice of the effective date; and c) I (We) have paid the premium in full. I (We) understand that any changes in my (our) health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of GTL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by GTL. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

AUTHORIZATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to the MIB. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

AUTHORIZATION/AGREEMENT (CONTINUED)

I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written modification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as GTL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by GTL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (We) choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at _____

Date City and State

_____

Signature of Applicant Signature of Applicant's Spouse (if applicable)

APPH3A-11 (5/12)

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, Illinois 60025

SPECIFIED CRITICAL ILLNESS COVERAGE

OUTLINE OF COVERAGE

For Policy Form G1132-AR
Rider Forms RG11CAN, RG11HAS, RG11NH, RG07ROP (D)

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your policy. This is not an insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY**!

SPECIFIED CRITICAL ILLNESS COVERAGE – Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a specified critical illness. The policy provides coverage for loss resulting from specified covered conditions, based upon the benefit plan chosen. See *BENEFIT PLANS* below for the covered conditions included for each benefit plan. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS

BENEFIT PLANS	COVERAGE INCLUDED FOR
Plan A – Critical Care	Covered Conditions: Cancer, Coronary Artery Bypass Surgery, Heart Attack, Stroke, Alzheimer's disease; kidney failure, paralysis, coma, major organ transplant. Nursing Home and Assisted Living Facility benefits when confinement is due to the Plan A Covered Conditions.
Plan B – Cancer Care+	Covered Conditions: Cancer, Alzheimer's disease; kidney failure, paralysis, coma, major organ transplant. Nursing Home and Assisted Living Facility benefits when confinement is due to the Plan B Covered Conditions.
Plan C – Cardiac Care+	Covered Conditions: Coronary Artery Bypass Surgery, Heart Attack, Stroke, Alzheimer's disease; kidney failure, paralysis, coma, major organ transplant. Nursing Home and Assisted Living Facility benefits when confinement is due to the Plan C Covered Conditions.

Upon the diagnosis of a covered condition, we will pay the monthly benefit amount you choose for the policy and any attached riders after the waiting period has been satisfied. We will pay this amount for the number of months you choose from 6 months to 24 months. A limited benefit period applies to cancer in situ, coma and heart attack (3 month benefit period) and coronary artery bypass (2 month benefit period.)

The monthly benefit amount is subject to:

1. The applicable maximum benefit period or limited benefit period;
2. The lifetime maximum benefit amount; and
3. The definitions, limitations, exclusions and other provisions of this policy.

For benefits to be payable, the following requirements must be met:

1. The diagnosis must be made while this policy is in force, and
2. The diagnosis must be made after the expiration of the waiting period, if any, and
3. All terms and conditions of this policy must be met.

We will pay the monthly benefit amount for only one covered condition during any one benefit period. We won't pay benefits for multiple covered conditions during any one benefit period.

Payment of any benefits under this policy and / or any attached riders will reduce the lifetime maximum benefit amount by the amount of any monthly benefit paid under this policy and /or any attached riders. When we have paid the applicable lifetime maximum benefit amount, the policy and any attached riders end.

In the event of your death during the maximum benefit period or limited benefit period, any remaining benefit payable under the policy and / or riders for that benefit period will be paid in a lump sum to your designated beneficiary.

RESTORATION OF POLICY BENEFITS

This Policy's Maximum Benefit Period or Limited Benefit Period for any One Benefit Period will be fully restored when there has been no payment of benefits of a Covered Condition for twelve (12) consecutive months. The Restoration of Policy Benefits does not apply to Alzheimer's disease or Paralysis.

If the Policy includes coverage for Cancer, as shown on the Policy Schedule Page, benefits for the reoccurrence of a previously diagnosed Cancer are subject to Documented Medical Evidence that supports a Cancer's Period of Remission. We retain the right to have such Documented Medical Evidence reviewed by an Oncologist of Our choice.

The Restoration of Policy Benefits is subject to the Lifetime Maximum Benefit shown in the Schedule.

OPTIONAL RETURN OF PREMIUM RIDER - In the event you die before the first policy anniversary which follows your eightieth (80^{th}) birthday, a Return of Premium Benefit may be payable to your named beneficiary or estate. Benefit payment under this rider is subject to the policy being in force with this rider at the time of your death.

The actual amount of premium that will be returned, if any, will equal:

1. The sum of all premiums you paid for the policy, including premiums paid for this rider and any other benefit rider(s) attached to the policy (unless expressly excluded), while this rider was in force (except for any application and annual policy fees). Premium also includes premiums paid for any dependent(s) insured under the policy. The sum of all premiums is without interest accumulation. MINUS

2. The sum of all benefits paid or then payable under the policy, including benefits paid or payable under any attached benefit riders, to you or on your behalf while this rider was in force.

If we receive a claim for benefits after proceeds have been paid under the terms of this rider, the amount of claim benefits due, if any, will be reduced by the amount of the Return of Premium Upon Death Benefit that has already been paid.

WAITING PERIOD – There is a 30 day waiting period before we will pay benefits for a loss covered by the policy and attached riders. We will not pay benefits for covered conditions diagnosed or procedures performed during the waiting period.

EXCLUSIONS - This Policy does not cover any loss caused by the following:

1. Any loss due to injury, disease or incapacity, unless related to or attributable to the Covered Conditions as defined.
2. Intentionally self-inflicted injury, while sane or insane.
3. Alcohol or drug abuse (unless drug abuse was a result of the administration of drugs as part of treatment by a Doctor).
4. Committing or attempting to commit a felony.
5. War (declared or undeclared) or any act of war, or service in any armed forces.
6. Engaging in an illegal occupation.
7. Participating in a riot or insurrection.
8. Injury sustained while taking part in any of the following activities:
   (a) Amateur or professional sports or athletics, except this does not include Amateur sports or athletics which are non-contact or undertaken solely for leisure, recreational, entertainment or fitness purposes.
   (b) Mountaineering where ropes or guides are normally used or at elevations of 4,500 meters or higher.
   (c) Aviation, except when travelling solely as a passenger in a commercial aircraft.
   (d) Hang gliding, sky diving, parachuting or bungee jumping.
   (e) Snow skiing or snowboarding, except for recreational downhill and /or cross-country snow skiing or snowboarding (no coverage provided whilst skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body);
   (f) Racing by any animal or motorized vehicle;
   (g) Spelunking;
   (h) Operating, riding in or upon, mounting or alighting from, any two, three, or four wheeled motor/engine driven snowmobile or all terrain vehicle (ATV).

Exclusion 8 applies only to the Covered Conditions of Paralysis and Coma.

RENEWABILITY – You may keep the policy and any attached riders, (except the Return of Premium Upon Death Benefit Rider, which ends the first policy anniversary date after the 80^{th} birthday) in force during your entire lifetime by paying premiums when due or within the grace period. We can't cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

PREMIUMS SUBJECT TO CHANGE - We may change your premium rates by giving you at least 31 days prior written notice. We can change the premiums this way only if we change them on a class basis for all policies/riders of this class in your state.

INITIAL PREMIUM

☐ **PLAN A - CRITICAL CARE**	**$_____**
☐ **PLAN B - CANCER CARE+**	**$_____**
☐ **PLAN C – CARDIAC CARE+**	**$ _____**
☐ **RETURN OF PREMIUM RIDER**	**$ _____**
ANNUAL POLICY FEE:	**$ _____**
TOTAL PREMIUM	**$ _____**

Agent Name:_____ Agent Address:_____

Telephone Number:_____

Guarantee Trust Life Insurance Company

Statement of Variability
For
APPH3A-11 (5/12) (Application)

Section B – Benefit Plans A through C will be offered. In the event additional plans (for example a higher monthly benefit amount) the rates and schedule pages for such plans will be filed for approval. However, we would not anticipate refiling the applications for this change. Instead our cover letter would indicate the application in use and that such application would be modified in the Coverage Selection only.

Variability is limited to changing these portions only in context that remains compliant with *(state)* regulatory requirements. Any new benefit plans, benefit periods, or premium rates will be filed with the *(state)* Department of Insurance before use. The Company reserves the right to discontinue marketing benefit riders not mandated under state law.

SERFF Tracking Number:	*GRTT-128294074*	*State:*	*Arkansas*
Filing Company:	*Guarantee Trust Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*RA12-5*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Amendment Rider*		
Project Name/Number:	*/RA12-5*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/23/2012	Supporting Document	Application	06/08/2012	APPH3A-11 (5 12).pdf (Superceded)

Application for Critical Care Insurance to: Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue, Glenview, IL 60025 (800) 338-7452

AGENT NOTE: Please pre-qualify the Applicant(s) with Section C prior to completing the application

Application for: ☐ New Coverage ☐ Reinstatement ☐ Increase of Benefits

If Reinstatement or Increase requested, please list GTL policy/certificate number(s) affected:_____

A. APPLICANT(S) INFORMATION

MAIL POLICY TO: ☐ AGENT ☐ INSURED

APPLICANT

1. Last Name _____ 2. First _____ 3. M.I _____

4. Social Security #_____ 5. ☐ Male ☐ Female 6. Age _____ 7. Date of birth_____

8. Have you used any tobacco products in the past 12 months? ☐ Yes ☐ No

SPOUSE:

9. Last Name _____ 10. First _____ 11. M.I _____

12. Social Security #_____ 13. ☐ Male ☐ Female 14. Age _____ 15. Date of Birth_____

16. Have you used any tobacco products in the past 12 months? ☐ Yes ☐ No

DEPENDENTS:

D1. Last Name _____ First _____ M.I _____
☐ Male ☐ Female Age _____ Date of Birth_____ Social Security #_____

D2. Last Name _____ First _____ M.I _____
☐ Male ☐ Female Age _____ Date of Birth_____ Social Security #_____

For additional dependents, please attach a separate piece of paper, signed and dated by the applicant, including the above information for each dependent.

CONTACT:

17. Street Address_____

18. City_____ 19. State_____ 20. Zip Code_____

21. Telephone_____ 22. Email Address _____

BENEFICIARY (Required Information):

Primary Beneficiary_____ Relationship_____

Contingent Beneficiary_____ Relationship_____

B. COVERAGE SELECTION & PREMIUMS

1. Choose a Plan:	2. Choose Benefit Amount	3. Choose Benefit Period
Plan Type (Select 1): A B C	*Monthly Base Benefit Amount: *Minimum $500, maximum $3,000 in $250 increments	**Maximum Benefit Period for covered conditions: 6 Months | 12 Months | 18 Months | 24 Months
Applicant: ☐ ☐ ☐	$_____	☐ ☐ ☐ ☐
Spouse: ☐ ☐ ☐	$_____	☐ ☐ ☐ ☐
Depndt(s): ☐ ☐ ☐	$500 (for all dependents)	☐ ☐ ☐ ☐
Plan A = Critical Care *Plan B = Cancer Care+* *Plan C = Cardiac Care+*	*Assisted Living Facility and Nursing Home Benefits are paid in addition to the base. The ALF benefit is 50% of the base, NH benefit is 100% of the base.*	***Limited Benefit Period applies to specific covered conditions. See Outline of Coverage.*

4. Choose Premium Payment Mode:

☐ Monthly Bank Draft ☐ Annual
☐ Semi-Annual ☐ Quarterly
Effective Date: _____
Draft Date (other than the 29th, 30th and 31st):_____

5. Return of Premium Rider: ☐ Yes ☐ No

6. Premiums:

Premiums include an annual $25 Policy Fee.
TOTAL: $ _____

C. PRE QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

1. In the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:

AIDS or ARC	Kidney Dialysis
ALS (Lou Gehrig's Disease)	Kidney Disease, Chronic
Alzheimer's Disease	Liver Disease, Chronic
Central Nervous System Disease	Mental Retardation
Cerebral Palsy	Motor Neuron Disease
Cirrhosis	Multiple Sclerosis
Crohn's Disease	Muscular Dystrophy
Cystic Fibrosis	Paralysis
Dementia	Parkinson's Disease
Hepatitis B, or C. Chronic	Respiratory or Lung Disease, Chronic
HIV positive	(other than controlled asthma)
Huntington's Disease	Ulcerative Colitis

2. In the past 5 years has anyone proposed for insurance been treated for drug or alcohol abuse or abused alcohol or drugs or had abnormal test results relating to alcohol or drug use or are currently confined to an assisted living facility or a nursing home?

3 For any of the conditions listed in 1 and 4 A-B for which benefits are being applied for, within the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a practitioner but has not yet done so or experienced any symptoms that would have caused an ordinarily prudent person to seek advice from a medical practitioner?

4. In the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:
   A. Leukemia, malignant melanoma, lymphoma, sarcoma, or any other type of cancer (excluding skin cancer) or any tumor of the brain?
   B. Disease of the heart or heart valves, heart attack, chest pain, coronary bypass, angioplasty, stent placement, angina, heart arrhythmia requiring treatment, cardiomyopathy, congenital heart defect, abnormal heart test, stroke, Transient Ischemic Attack (TIA), peripheral vascular disease, unoperated aneurysm, brain hemorrhage or diabetes treated with insulin?

5. For anyone proposed for insurance under the age of 60, did 2 or more of your natural parent(s), sister(s), brother(s), either living or dead suffer from:
   A. Cancer before the age of 60?
   B. Stroke or heart disease or diabetes before the age of 60?

6. Is any person proposed for insurance taking any prescription medication? If yes please list below.

Name of Person	Name of Medication	Reason for Medication(s)	Dosage

APPLICANT'S ANSWERS

Question	YES	NO	Action
1, or 2, or 3	☐	☐	If "YES," do not submit the application
4A, or 5A	☐	☐	If "YES," Cancer Care coverage not available } If both "YES", do not submit application
4B, or 5B	☐	☐	If "YES," Cardiac Care coverage not available

SPOUSE'S ANSWERS

Question	YES	NO	Action
1, or 2, or 3	☐	☐	If "YES," Spouse does not qualify for benefits
4A, or 5A	☐	☐	If "YES," Cancer Care coverage not available } If both "YES", does not qualify for benefits
4B, or 5B	☐	☐	If "YES," Cardiac Care coverage not available

DEPENDENT'S ANSWERS

Question	YES	NO	Action
1, or 2, or 3	☐	☐	If "YES," Dependent(s)_____ does/do not qualify for benefits
4A, or 5A	☐	☐	If "YES," Cancer Care coverage not available } If both "YES", does/do not qualify for benefits
4B, or 5B	☐	☐	If "YES," Cardiac Care coverage not available

D. COVERAGE INFORMATION

APPLICANT

1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued? ☐ No ☐ Yes (If "YES," please complete the Replacement Form.)
   If "YES," with which company? _____

AGENT'S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by Guarantee Trust Life Insurance Company. To the best of my knowledge and belief, the insurance applied for:

☐ Is, or

☐ Is not likely to replace or change existing insurance or annuities.

_____

Agent's Name (Printed) Agent Code

_____

Agent's Signature Agent's Email Address Date

AUTHORIZATION/AGREEMENT

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that insurance applied for will not become effective until: a) approved and issued by GTL; b) I (We) have been furnished written notice of the effective date; and c) I (We) have paid the premium in full. I (We) understand that any changes in my (our) health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of GTL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by GTL. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

AUTHORIZATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to the MIB. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

AUTHORIZATION/AGREEMENT (CONTINUED)

I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written modification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as GTL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by GTL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (We) choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at _____

Date City and State

_____

Signature of Applicant Signature of Applicant's Spouse (if applicable)

APPH3A-11 (5/12)